


NF39D Form DCSC	Health Information and Quality Authority Designated Centre – Special Care Unit (DCSC) Quarterly notification of incidents* NF39D Any injury to a resident that did not require notification within 3 days	 <p>Health Information and Quality Authority <small>An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte</small></p>
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Section 1. Centre details			For official use
Centre name			<input type="checkbox"/>
Centre ID (OSV)			<input type="checkbox"/>
Unit or ward name (if applicable)			<input type="checkbox"/>
Please tick the applicable quarter and state the year.			
Quarter 1 (January, February, March)	<input type="checkbox"/>	Year	<input type="checkbox"/>
Quarter 2 (April, May, June)	<input type="checkbox"/>	Year	
Quarter 3 (July, August, September)	<input type="checkbox"/>	Year	
Quarter 4 (October, November, December)	<input type="checkbox"/>	Year	

* Please complete this form with HIQA's notification guidance. You can download the guidance at www.hiqa.ie

Section 2. Non-serious injury to a resident		For official use
Any occasion where an injury occurs and does not require an NF03		
Has there been a non-serious injury [†] to a resident or residents in the quarter?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
How many non-serious injuries have occurred in the quarter?		<input type="checkbox"/>
How many residents were injured?		<input type="checkbox"/>
What is the type of injury? Please tick the relevant box or boxes.	Minor wound <input type="checkbox"/>	<input type="checkbox"/>
	Minor cut or abrasion <input type="checkbox"/>	
	Minor sprain <input type="checkbox"/>	
	Minor burn <input type="checkbox"/>	
	Other <input type="checkbox"/>	
If other , please provide details.		
Please include any additional information relevant to this section.		
		<input type="checkbox"/>

[†] An injury that does not require medical attention.

Section 3. Declaration		For official use
I, the undersigned, declare that the information I have provided in this notification form is true to the best of my knowledge and belief.		
Name (print)		<input type="checkbox"/>
Position	Person in charge	<input type="checkbox"/>
	Authorised signatory for and on behalf of the registered provider	<input type="checkbox"/>
Signed		<input type="checkbox"/>
Date		<input type="checkbox"/>
Contact number (during office hours)		<input type="checkbox"/>

This form should be either:

- **emailed** to: children@hiqa.ie or,
- **posted** to: Children Regulatory Support Team, Regulatory Support Services, Health Information and Quality Authority, Dublin Regional Office, George's Court, George's Lane, Smithfield, Dublin 7, D07 E98Y.

Telephone no: (01) 814 7400

Email: children@hiqa.ie